PEDIATRIC VISIT 2 to 3 MONTHS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% HC_____/_____% TEMP_____

HISTORY:

Family health history documented & updated?_____
Perinatal history documented & updated?_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Sleep: **Child care:**
Maternal Depression? Yes / No

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move,
Loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:
History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No
Risk Assessment: TB Circle: **Positive / Negative (Annual)**

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
		_____
☐	☐	Skin
		_____
☐	☐	Head/Face/Fontanelles
☐	☐	Eyes/Red reflex/Cover test
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Gums/Dentition
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals
		_____
☐	☐	Extremities/Hips/Feet
☐	☐	Neuro/Reflexes/Tone
		_____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

_____

_____

NUTRITIONAL ASSESSMENT:

Breast/bottle: Amount & frequency _____

Bowel/bladder: Number of wet _____, dry _____ in 24 hours?
Number BM's in 24 hours? _____

Education: Hold to feed ☐ Use of pacifier ☐
If breast fed, Vitamin D ☐ Feed on demand ☐
Growth spurts ☐ Avoid solid foods until 4-6 months ☐

DEVELOPMENTAL SURVEILLANCE: *(**O**bserved or **R**eported)*

Social: Regards face ☐ Alert ☐ Social smile ☐

Fine Motor: Follows 90 degrees ☐ Grasps ☐

Language: Coos ☐ Laughs ☐

Gross Motor: Head steady when sitting ☐ Hand brought to mouth ☐

ANTICIPATORY GUIDANCE:

Social: Time out for parent ☐ Parental adjustment ☐ Sibling rivalry ☐
Father's involvement ☐

Parenting: Comfort often ☐ Infant developing trust ☐
Holding much of time when awake ☐
Temperaments differ among infants ☐

Play and communication: Infant seat ☐ Mobiles, music, pictures ☐
Talk or sing to baby ☐ Objects to kick or bat at ☐

Health: Fever/taking temp ☐ Rashes ☐ Diarrhea ☐
Second hand smoke ☐

Injury prevention: Rear riding/rear facing infant car seat ☐
Smoke detector/escape plan ☐ Hot liquids ☐ Poison control # ☐
Hot water set at 120º ☐ Water safety (tub/pool) ☐
Choking/suffocation ☐ Firearms (owner risk/safe storage) ☐
Fall prevention (heights) ☐ Don't leave unattended ☐

PLANS/ORDERS/REFERRALS

1. Immunizations ordered ☐ _____
2. Second metabolic screen, if not done earlier ☐ _____
3. Follow up newborn hearing screen ☐ _____
4. Next preventive appointment at 4 months ☐
5. Referrals for identified problems? *(specify)*

_____

_____

_____

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Signatures: _____